DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

VETERAN OVERSIGHT NOW PODCAST TRANSCRIPT

DAVID CASE, DEPUTY INSPECTOR GENERAL, DISCUSSES RECENT OVERSIGHT WORK RELATED TO VA'S ELECTRONIC HEALTH RECORD MODERNIZATION

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Fred Baker:

Welcome back to another podcast episode of veteran oversight now. The official podcast of the VA Office of Inspector General. I'm your host Fred Baker.

Each month on this podcast we'll bring you highlights of the VA OIG's recent oversight activities and interview key stakeholders in the office's critical work for veterans.

Today we're excited to have a guest host here to discuss a very important topic for VA and veterans receiving VA healthcare – the electronic health record modernization program. The VA OIG last week released three reports detailing deficiencies following the 2020 implementation of the new electronic health record (new EHR) at the Mann-Grandstaff VA Medical Center in Spokane, Washington.

With me today is Deputy Inspector General Dave Case, who has worked closely with the teams as they have developed these and other oversight reports on this topic for the past couple of years. He is interviewing one of the lead authors of these reports, Dr. Joe Etherage. Dr. Etherage is Dr. Etherage is a psychologist and works in the OIG's Office of Healthcare Inspections where he serves as the director of national reporting.

With those introductions, I'll turn it over to our guest host, welcome Deputy Inspector General Case.

David Case, Deputy Inspector General:

Thank you, Fred.

Joe, could you describe the reports that were recently published on the implementation of the new electronic health record at the Mann-Grandstaff facility?

Joseph Etherage:

Certainly. Thank you, Mr. Case. Thanks for the opportunity to connect and review our trilogy of recently published reports addressing these multiple concerns with VA's new electronic health record or EHR.

Multiple folks contacted our OIG hotline and raised alarms to EHR following the go-live of that EHR at Mann Grandstaff, VA Medical Center in Spokane, Washington. Congressional members also relayed multiple concerns raised by their constituents.

David Case, Deputy Inspector General:

Now I understand two healthcare inspections were performed addressing a total of 57 allegations. How are the 57 allegations selected?

Joseph Etherage:

So, we did conduct those two healthcare inspections. Each team covering a topic from those 57 allegations. We got to the 57 allegations by reviewing those concerns that were raised through the OIG hotline and then also through constituents that had contacted their congressional members, and then from there generated those 57 allegations.

Sometimes we would have repeats of concerns and so, in that case, those similar concerns would be put together until we reviewed and came up with that final set of 57 allegations.

David Case, Deputy Inspector General:

Now I understand one inspection team focused on medication management allegations and another team investigated care coordination allegations.

Now I understand medication management to include all the elements of patient care, concern use of the EHR for safe medication treatment. That would include tracking and managing lists of patients' medications, ordering medications, and getting medications to patients timely. So, what is addressed under the topic of coordination of care?

Joseph Etherage:

Coordination of care is this very broad term that wound up incorporating an expansive list of allegations. But, at the end of the day, care coordination is about how we synchronize care. The communication of healthcare between health care providers, and then also between health care providers and the patient.

David Case, Deputy Inspector General:

Alright, so that's the second report on care coordination. What's the third report in this trilogy of reports on VA's new electronic health record.

Joseph Etherage:

So, during the course of our two inspections as those teams did their work, we identified some challenges with the ticket process. So, when I say ticket process, I mean the process that users that were using the new EHR would use to request help, either for a fix or a change to the EHR.

So, in addition to looking at and identifying concerns for the ticket process, we also found that by identifying underlying factors to that large group of allegations, it helped us to further understanding, helped further our understanding of the allegations.

So as a result, we completed a third report that discussed those two key issues. First, what were the challenges to its ticket process—and then second what—what were those underlying factors for the 57 allegations?

David Case, Deputy Inspector General:

So, for the trilogy there were a total of six recommendations to Veterans Affairs. All these recommendations were directed to the deputy secretary.

Why were they directed to the deputy secretary?

Joseph Etherage:

Two reasons. So, first Congress has made that office, the office of the deputy secretary, the accountable official for the VA's EHR modernization effort.

Second, we found that during our inspection work that these issues were systemic. They weren't tied specifically to Spokane, and therefore our recommendations should go to the deputy secretary.

David Case, Deputy Inspector General:

Well now, once the determination of allegations was completed in June of 2021, was there a determination of whether the allegations were substantiated or not?

Joseph Etherage:

There was, and I think that brings up an important point. So, when VA responded to our trilogy and in early March of 2022, nearly a year and a half following go-live, VA stated that it had coordinated to address only three of the 21 substantiated and unresolved allegations cited in the medication management report and only five of the 16 substantiated and unresolved allegations in the clinical coordination report.

Bottom line is that the allegations we found as substantiated and unresolved largely remained unresolved as we record this today.

David Case, Deputy Inspector General:

Now what was done to investigate these allegations?

Joseph Etherage:

I think it's an important point to emphasize the efforts we go to accurately understand and evaluate allegations. The inspection teams from January to August 2021 conducted more than 30 interviews,

ranging from the frontline staff there at Mann Grandstaff VA Medical Center to senior leaders in VA's Office of Electronic Health Record Modernization.

We also gained access to the EHR problem ticket system and analyze troubled tickets.

The analysis included tickets from VA and Cerner, from go-live through March 31, 2021. New EHR end users placed over 38,700 tickets.

To better understand the allegations, we identified some key terms for each of those 57 allegations and then two healthcare inspectors checked and crosscheck 4094 tickets that we identified through our keyword search.

Our reports focused on tickets related to the allegations. We did not attempt to address all the concerns with the new EHR identified by facility staff.

David Case, Deputy Inspector General:

Now as part of this process, were you and your staff working on this able to visit the Mann- Grandstaff facility?

Joseph Etherage:

I'd like to add, some members of the inspection team have been involved in oversight work for EHR modernization now for a number of years. Prior to the pandemic, we had made visits to the Mann-Grandstaff VA Medical Center in Spokane, Washington. And then in January 2021, our deputy assistant inspector general visited Mann-Grandstaff at the invitation of the former acting under secretary of health Dr. Stone.

And I think this is an important, a really important point, we found that facility leaders and staff remain undeterred and dedicated to taking care of patients despite the added burden of, COVID-19 pandemic stressors and the challenges with the new EHR.

David Case, Deputy Inspector General:

Now the first report on medication management addressed 23 allegations. Did these allegations break down into more general categories?

Joseph Etherage:

They did. In the report, we grouped those allegations into three categories. The first was data migration, the second medication orders, and then finally, the third, medication reconciliation.

An example of the data migration category was an allegation we substantiated that found that when healthcare providers prescribed a medication, they could be presented with a long list of options for just one medication, but that a bunch of those medications might not even be available at the facility.

David Case, Deputy Inspector General:

Now in reviewing the report, I see the report has a screenshot of this list of medications. Can you describe the challenge this long list of medications creates?

Joseph Etherage:

I can. So, imagine you're in a restaurant, and the menu includes 50 listings for cheese pizza.

Some versions of the cheese pizza have 12 slices. Some might have 10. But they're all very, very similar. You're not sure which one to choose, and you make your order. However, it turns out that you've ordered a version of the cheese pizza that the restaurant doesn't even have. That's one of the challenges healthcare providers spaced with prescribing.

David Case, Deputy Inspector General:

Now how is it that you can have something on the menu—one cheese pizza—but it's not available?

Joseph Etherage:

A good question, and it comes down to at the end of the day, a menu that isn't accurate—a list of medications that doesn't accurately reflect what's available at the facility and that's one of the one of the challenges that are prescribers there at Mann-Grandstaff faced.

David Case, Deputy Inspector General:

So, tell me how many of the allegations on data migration were substantiated?

Joseph Etherage:

So, we substantiated all four allegations that were related to data migration, and we found that all were unresolved at the time of our inspection. With that medication orders category, we substantiated 10 of the 12 medication order allegations and again found that they were all unresolved at the time of our inspection. An example would be the finding that nurses were able to order medications without the medication orders being reviewed and approved by the medical provider.

That third category, medication reconciliation, I think deserves a little bit a preface to better understand what we're talking about. So, a healthcare team reconciles the list of the patient medications to ensure the team and the patient have an accurate accounting of medications of patients prescribed.

It was alleged that medications disappeared from the reconciled medication list and medication lists were inaccurate following reconciliation. We wound up substantiating all seven of those medication reconciliation allegations, and again found they were all unresolved at the time of inspection.

David Case, Deputy Inspector General:

Well, to me the bottom line is that you found that 21 of the allegations concerning medication management were substantiated but unresolved. How did those 21 substantiated but unresolved allegations translate into the two recommendations for medication management?

Joseph Etherage:

So, one recommendation was the same for this report as well as the care coordination report that we'll cover next. We made a recommendation that the VA deputy secretary ensure that those substantiated and unresolved allegations be reviewed and then addressed. And VA concurred with that recommendation for both of the reports.

David Case, Deputy Inspector General:

Now to follow along here, I understand that the second recommendation in the medication management report was that the deputy secretary ensure medication management issues related to the new electronic health record that are identified after the inspection be reported to the Office of Inspector General for further analysis.

Joseph Etherage:

Yes, that's it. It was a first for me in my work in the OIG, but VA did not concur with this recommendation.

David Case, Deputy Inspector General:

Now to me, VA's decision to non-concur with this recommendation raises real issues. First, it's not an open-ended recommendation and would be closed when VA demonstrates that there is an effective sustainable process to identify and address patient safety concerns. In addition, the VA is just slamming the door on one avenue of continued discussion about the new electronic health record.

With regard to this non-concur, what actions will OIG take in response?

Joseph Etherage:

Well, we are going to continue to vigorously pursue patient safety issues identified with the new EHR.

David Case, Deputy Inspector General:

As veterans ourselves, I think we're especially sensitive to the role of oversight and ensuring quality and safe health care at the VA. For the second report, on clinical coordination, there were eight category validations. What issues were addressed by the OIG?

Joseph Etherage:

Right, so yeah, eight categories, so a larger number than that first medication report.

This second inspection covered a broad range of concerns.

I have an example of a challenge with care coordination. So the new EHR also has a new patient portal. So, we've learned that following go-live the facilities coordinator for the new portal reported a backlog of over 300 voicemail messages from patients requesting help due to being unable to access the new EHR's patient portal. To give you a sense of what this means, a call with a patient to help out could be an hour long.

David Case, Deputy Inspector General:

Now the patient portal was one category for coordination concerns. Another allegation category included data migration. Could you describe in this context what that means here?

Joseph Etherage:

Yes. So, we saw the DoD system overwrite VA data, which led to incorrect names, sometimes genders and contact information, in the new HR for some patients.

So, imagine that you're in the waiting room for an appointment and you've been called back but the name from your divorce years ago is used and you're told that you're going to have to now find your divorce paperwork and work to have your information fixed.

David Case, Deputy Inspector General:

While this example, certainly illustrates some of the frustrations caused by the data migration issue, what other categories of issues were addressed in the care coordination?

Joseph Etherage:

So other categories included patient risk flags—or excuse me patient record flags. So, for example, a flag in the system that lets the healthcare team know that a patient might be at risk for suicide. All six of those allegations were substantiated.

We also substantiated five of nine allegations related to scheduling problems, three of five allegations with documentation, three of four lab orders allegations, and three of four allegations with referrals, like when your primary care doctor refers you to a specialist. Three of five allegations with telehealth problems were also substantiated. We also found that many of these substantiated allegations had not been resolved.

David Case, Deputy Inspector General:

You shared that the third report addressed problems with the ticket process and identified underlying factors of costs allocations. How did this third report develop?

Joseph Etherage:

So, as part of our effort to review the allegations, we gained access to the ticket system and then conducted a review that was reviewed and cross-checked by two of our healthcare inspectors.

David Case, Deputy Inspector General:

How many tickets were reviewed?

Joseph Etherage:

Over 4000 tickets. I did not envy our folks that took on that massive task, but they did an excellent job. It helped us to better understand many of the allegations and also to understand the challenges, Mann-Grandstaff faced when they sought help for a change or a fix of the new EHR.

We identified four challenges with the ticket process. The two that I would like to point out are, first, we found that our frequent concern was that the loop didn't get closed. There was a problem with end users consistently getting a status back on their tickets. Second, we learned that many users got what I'd call ticket fatigue from placing so many tickets and then wound up creating work-arounds for their problems instead of placing tickets.

David Case, Deputy Inspector General:

By creating work arounds does that present any potential or risk to impact safety?

Joseph Etherage:

It does. We know that can be the case with work-arounds because, while well-intentioned, work-arounds can also introduce opportunities for mistakes to be made.

David Case, Deputy Inspector General:

Then in the third report the teams identified five factors underlying the allegations from both reports. Can you elaborate on that a bit?

Joseph Etherage:

I can. So, we did. By going back and reviewing the allegations, we found five factors which we believe helped to better understand the concerns with the new EHR that we addressed in those first two reports.

Those five factors were: first, EHR usability problems. Some examples of this were that information sometimes could be segregated, kind of split across different screens. Users could have significant difficulties with navigating around the EHR. And we also found that because of restrictions to what people could view based on their role they've been assigned in the EHR, that could also create usability problems.

The second category that we identified were interoperability challenges, and this included problems with correcting data errors or inconsistencies, challenges with the mail order pharmacy, and then also the connection between the new EHR and reporting tools that already existed. A good example of this would be a tool that suicide prevention coordinators view to help monitor and support patients again at risk for suicide.

The third factor was a post go-live fix and refinement needs, and this is something we would expect. The new EHR brings new challenges and some things that are going to need to get fixed. And, so, we did find that that was certainly the case with the new EHR at Mann-Grandstaff—that there were multiple allegations that were tied to needed fixes there following go-live.

The fourth category is what we refer to as problem resolution process challenges, and this is really that ticket process problem that we talked about prior.

And then the final category is training deficits, and this included training content that we found lacking, A lack of direct support to staff, and then an approach to training that was referred to as “buttonology”—this idea that people would be told what buttons to press in certain orders, but really not understand the reasons why, and the understanding, and understanding the process behind the work that they were doing in the new EHR.

David Case, Deputy Inspector General:

So, the last general area you just discussed was these deficits and training for the EHR. Is that a topic that has been covered in detail in prior OIG reports?

Joseph Etherage:

It is. So, we do have a prior report that that goes into much greater detail, talking about the training deficits that we identified for the new EHR.

David Case, Deputy Inspector General:

So, this final report, are there particular recommendations that were made to the deputy secretary?

Joseph Etherage:

Yes. Again, the recommendations did go to the deputy secretary and we made three of them. Those three recommendations were that, first we recommended that the deputy secretary complete an evaluation of those challenges with resolving problems that have been identified through tickets and then take action to address what's found from that evaluation.

The second recommendation is that the deputy secretary oversee completion of an evaluation of those underlying factors. We identified and then again, following that evaluation, take action based on those findings. And then finally we recommended that the electronic health record modernization deployment schedule reflect resolution of the allegations and concerns that we identified across these three reports.

David Case, Deputy Inspector General:

One final question here, Joe. Given the scope and breadth of these three reports and all the findings and then recommendations—Is it safe for a veteran to go to the Mann-Grandstaff facility?

Joseph Etherage:

So, yes. Yes, I would, and the reason why comes down to the people. So as an individual who receives his care through the VA, I consistently am impressed by the dedication and the quality of care that I receive from the folks that work at the VA. And so, for that reason, I know that, despite some of the challenges that we've identified through this report, that the people working at VA facilities are going to ensure and do their best to make sure that I and other veterans receive quality, safe care.

David Case, Deputy Inspector General:

I really much appreciate it.

So, thanks, Joe. This has been a really helpful discussion, I think. And for everyone, these three reports are now available through our OIG website. And folks should know that the OIG podcasts are produced by OIG staff. You'll find other OIG podcasts in the media section of our website.

Fred Baker:

Thanks again to Deputy Inspector General Dave Case and Dr. Joe Etherage for being willing to come on the podcast. I hope you found it interesting and informative.

OK, now I'll turn it over to Adam Roy for this month's highlights. Take it, Adam.

Adam Roy:

Thanks Fred. Here are some of the VA OIG's highlighted work for February 2022. If you want to read all monthly highlights for February, check them out on our website. Go the homepage, select the publications tab and click on monthly highlights.

I'll start with some recent congressional testimony. On February 3rd, Dr. Julie Kroviak, the deputy assistant general for Healthcare Inspections, testified before the House Veterans Affairs' Subcommittee on Health. Her testimony focused on the findings and recommendations from the OIG's five published vet center inspection reports. The reports identified a need for continued VA leadership engagement at all levels and greater attention to training, internal controls, and oversight. In response to questions, Dr. Kroviak discussed the need for better documentation of vet center processes and an improved record-keeping system. The Vet Center Inspection Program is a relatively new program to the VA OIG. And Dr. Kroviak actually joined us recently on Veteran Oversight Now, our official podcast, where she discussed the vet center inspection program, often called VCIP. In the episode, host, Fred Baker, and Dr. Kroviak discuss her journey from medical student to VA doctor to leading teams conducting oversight of VHA. She introduces the new VCIP program, detailing how the VA OIG will inspect roughly 300 vet centers over the next few years. It's an interesting episode. I encourage you to listen to it and check it out. You can find it on our website under the media tab.

I'm now going to share a few updates to investigations our agents pursued.

As a result of a joint investigation by multiple federal agencies, including the VA OIG's Northeast and Northwestern field offices, government contractor, TriMark USA, agreed to pay a record $48.5 million settlement to resolve claims related to fraudulent procurement of small business contracts intended for service-disabled veterans. The company, based in Mansfield, Massachusetts, provides kitchen and food service equipment to federal customers. This settlement constitutes the largest-ever False Claims Act recovery based on allegations of small business contracting fraud.

Some background here, between 2011 and 2021, the company identified federal set-aside contract opportunities for the small businesses to bid on using their set-aside status; helped them prepare their bids and what prices to propose; "ghostwrote" emails for those companies to send to government officials to make it appear as though the small businesses were performing work; and concealed its involvement in the contract. VA will receive over $10 million as a result of this settlement.

To quote VA Inspector General Michael Missal, "The Department of Veterans Affairs Office of Inspector General is committed to identifying and stopping those individuals who misappropriate an opportunity meant solely for our nation's veterans with disabilities…We appreciate the exhaustive efforts of our law enforcement partners and both U.S. Attorney's Offices in this collaborative effort."

A New Jersey man pleaded guilty for his role in a healthcare fraud scheme. From 2014 through 2016, he conspired to commit healthcare fraud against the government by unnecessarily prescribing and billing for compound medication through a VA vendor and a coconspirator pharmacy. The pharmacy received over $8 million in reimbursements through federal healthcare programs.

In a third case, a veteran pleaded guilty to assault with a deadly weapon. The VA OIG and Las Vegas Metropolitan Police Department investigated that on multiple occasions, this veteran threatened to kill himself and VA employees during calls to the VA Hotline, White House VA Hotline, and VA Crisis Line. On one occasion, the veteran said he possessed weapons, had the knowledge to build chemical weapons, and established a timeline to start killing people.

The owner of a telemarketing company and multiple durable medical equipment supply companies was sentenced in the Middle District of Florida to 15 years in prison for his role in two consecutive conspiracies to commit healthcare fraud. Beginning around January 2018 to around April 2019, the defendant and his coconspirators generated medically unnecessary physicians' orders via a telemarketing operation for durable medical equipment. Now to avoid scrutiny, the defendant spread the fraudulent claims across five storefronts operated under his ownership and control. This scheme led to about $25 million in fraudulent claims submitted to Medicare, resulting in approximately $12 million in payments.

Then, in April 2019, the storefronts were subject to search warrants and a civil action under which, among other ramifications, ordered the defendant and his five storefronts from engaging in any further healthcare fraud conduct. Undeterred, he and other conspirators carried out a similar conspiracy using three new storefronts and different telemedicine vendors. This second conspiracy caused approximately

$12 million in additional fraudulent claims to be submitted to Medicare, resulting in approximately $6.3 million in payments.

And finally, in another case, a veteran was sentenced to 12 months in prison and three years of supervised release after previously pleading guilty to influencing, impeding, or retaliating against a federal employee by threatening a family member. A VA OIG investigation determined that the veteran sent a threatening text message to his VA social worker's government-issued cell phone after he was discharged from government-provided housing. The veteran threatened to kill the social worker's family members because he blamed the social worker for his removal from the program.

Now to published reports.

In February, the VA OIG Office of Audits and Evaluations published an independent review of *VA's Special Disabilities Capacity Report for Fiscal Year 2020*. Some background: every year, VA must report to Congress on its capacity in five areas: (1) spinal cord injuries and disorders, (2) traumatic brain injury, (3) blindness, (4) prosthetics, and (5) mental health issues. The requirement was established to ensure that VA's capacity to serve disabled veterans does not fall below 1996 levels. In turn, the VA OIG is also required to report to Congress on the accuracy of this VA report. Our review team identified some minor errors, inaccuracies, and inconsistencies, which persisted from the fiscal year 2019 report. However, nothing came to the review team's attention that would lead the OIG to believe the information in the fiscal year 2020 capacity report was not otherwise fairly stated and accurate.

VA officials reported that they will address the errors, such as those related to reporting data on discrete intensive care teams for veterans with serious mental illness, in future capacity reports. It was also noted that VA officials were unable to correct the fiscal year 2020 report in response to the errors the OIG identified in its review of the fiscal year 2019 report because VA submitted its 2020 report before the OIG issued its review of VA's fiscal year 2019 report.

Key report takeaways include, and I'm quoting from the report, "VA does not and cannot meet the requirement to compare its mental health capacity with 1996 levels because of changes in medical diagnoses, treatments, treatment settings, infrastructure, information technology, data systems, and terminology. Furthermore, even if VA could compare capacity to 1996 levels, such reporting would not provide Congress with assurance that VA's capacity is adequate to provide care to these high-risk veterans. The OIG believes that Congress would be better informed by modernizing the reporting metrics to assess VA's capacity to provide care for veterans with spinal cord injuries and disorders, traumatic brain injuries, blindness, or mental illness and those who need prosthetics and sensory aids." Find the full report on our website.

In a second report, the VA OIG also conducted a healthcare inspection at the Martinsburg VA Medical Center in West Virginia to assess allegations of failure to schedule a Care in the Community COVID Priority 1 cardiology consult within Veterans Health Administration requirements, and delays in consult scheduling caused by inadequate staffing. The OIG substantiated these allegations. Specifically, the

report outlines that staff did not schedule the consult within 30 days of the CID; however, the patient did not experience an adverse clinical outcome based on the delay. The patient's cardiology consult was among a backlog of nearly 4,000 consults in an active, unscheduled status. Several factors contributed to the backlog and mismanagement of the consult process. Taken from the report, and I'll quote here, "the facility consistently failed to meet 90 percent of active consults scheduled within 30 days, one of the national metrics used to help manage Care in the Community consults. Despite failing to meet this metric, the facility did not have an Improvement Action Plan in place as required by the Office of Community Care. In addition, staff lacked awareness and did not make use of available reports to track and manage consults." The report further detailed, that in response to the increased volume of consults and high demands to schedule appointments urgently, the facility created several workarounds in an attempt to meet expectations. These workarounds, which included the misuse of COVID Priority 1 designation, and the use of unstandardized guidelines created more confusion with an already complicated process. Inadequate staffing with the Care in the Community Service caused scheduling delays as well. The VA OIG found that the facility had frequent staff turnover, which may have been attributed to lack of appropriate training and lack of alternative work options during the pandemic. The OIG made eight recommendations. Find this report and others on our website.

That's it for February's highlights.

If you want report summaries delivered right to your inbox, visit our website and sign up on our home page for email alerts. Thanks for tuning in.

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